Assessment of the Pilot Test and First Year of the Medicare & You Education Program

1998-1999

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Acknowledgments

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Executive Summary

The Balanced Budget Act of 1997 mandated the most significant changes to Medicare since its inception. One of these changes was the expansion of health insurance options by the creation of Medicare+Choice. To support the new program and to help Medicare beneficiaries make more informed health care decisions, the Health Care Financing Administration (HCFA) initiated the National Medicare Education Program (NMEP), called Medicare & You. The NMEP employs numerous communication vehicles to educate beneficiaries and help them make more informed decisions concerning: Medicare program benefits; health plan choices; supplemental health insurance; beneficiary rights, responsibilities, and protections; and health behaviors. A pilot program of specific NMEP activities afforded an opportunity to study and monitor the way these specific information channels function. Two key NMEP components implemented and tested in five pilot states (Oregon, Washington, Arizona, Florida and Ohio) prior to the planned nationwide implementation in Fall 1999 were the new Medicare & You Handbook and the toll-free Medicare Choices Helpline. This phased implementation allowed HCFA to improve new NMEP activities through performance monitoring and assessment prior to the nationwide implementation.

HCFA is taking a multifaceted approach to testing our overall approach to educating beneficiaries about Medicare. We have developed a performance assessment system for all elements of National Medicare Education Program (NMEP) to use for continuous quality improvement. The channel-specific assessments cover the following: print materials; toll-free telephone services (1-800-MEDICARE); the Internet (www.medicare.gov); regional education about choices in health (REACH); national alliance network; national training and support for information givers; and enhanced beneficiary counseling from the State Health Insurance and Assistance Programs (SHIP). These assessment activities identify what is working well and what needs to be improved for each of the mechanisms for communicating information about Medicare and Medicare+Choice. Additionally, we are conducting case studies in five communities in the five pilot states (Dayton, OH, Eugene, OR, Olympia, WA, Sarasota, FL, and Tucson, AZ), and in one community (Springfield, MA) outside the five pilot states, in order to describe the evolution of the NMEP in these six communities and identify “best practices” that could be used in other areas. The case studies add to our other assessment activities by providing information about how all of the activities related to the NMEP work together at the local level. We are continuing to monitor the case study sites over time.

To evaluate the impact of the NMEP at the national level, we have added a supplement to the winter round of the 1999 Medicare Current Beneficiary Survey (MCBS). This supplement will gather information about the ability of beneficiaries to obtain Medicare information when they need it, and about their awareness and understanding of Medicare and Medicare+Choice messages. We will be repeating this supplement in subsequent years. Since the MCBS only surveys current enrollees, we have developed separate surveys for new enrollees and for new health plan members addressing the same issues.

Introduction and Background

The Balanced Budget Act of 1997 mandated the most significant changes to Medicare since its inception. One of these changes was the expansion of health insurance options by the creation of Medicare+Choice. To support the new program and to help Medicare beneficiaries make more informed health care decisions, the Health Care Financing Administration (HCFA) initiated the National Medicare Education Program (NMEP) called Medicare & You. The NMEP employs numerous communication vehicles to educate beneficiaries and help them make more informed decisions concerning: Medicare program benefits; health plan choices; supplemental health insurance; beneficiary rights, responsibilities, and protections; and health behaviors. The primary objectives of the education efforts are to ensure that beneficiaries receive accurate, reliable information; have the ability to access information when they need it; understand the information needed to make informed choices; and perceive the NMEP (and the federal government and its private sector partners) as trusted and credible sources of information.

A variety of communication and information sharing mechanisms are being used through the NMEP including: print materials; toll-free telephone services; Internet sites; regional education about choices in health (REACH); national alliance network; national training and support for information givers; and enhanced beneficiary counseling from State Health Insurance Assistance Programs. To increase awareness of the Medicare & You information channels, a Promotion and Publicity Office has recently been created to promote and publicize the Medicare & You information channels through an integrated campaign. Other components of the NMEP are cross-cutting and comprehensive assessments of the education efforts, as well as consumer testing of all publications and materials. Attachment A includes a chart with a breakout of costs for fiscal years 1998 and 1999.

Providing 39 million Medicare beneficiaries with the knowledge and skills needed to make fully-informed choices about their coverage options is challenging. The Medicare population is very diverse in terms of education and literacy, and a large part of the beneficiary population is not currently well informed about Medicare-related topics. Thirty-eight percent of the Medicare population has less than 12 years of education; about 23 percent has less than 9 years of schooling. Approximately 44 percent of adults 65 and over are considered to have limited reading skills (Kirsch, Jungebult, Jenkins and Kolstad 1993). Almost 57 percent of beneficiaries report that they know only a little or almost none of what they need to know about the availability and benefits of Medicare health maintenance organizations, or HMOs (HCFA 1999).

The NMEP is a dynamic program, and HCFA is systematically studying the information needs of beneficiaries, their advocates, and its own partners to continually make enhancements and improve program efficiency. A pilot program of specific NMEP activities afforded an opportunity to study and monitor the way these specific information channels function. Two key NMEP components implemented and tested in five pilot states (Oregon, Washington, Arizona, Florida and Ohio) prior to the planned nationwide implementation in Fall 1999 were the new Medicare & You Handbook, and the toll-free Medicare Choices Helpline. This phased implementation allowed HCFA to improve new NMEP activities through performance monitoring and assessment prior to nationwide implementation.

Other monitoring activities are underway to assess each of the mechanisms used to communicate with Medicare beneficiaries. The results of the monitoring activities are routinely reported to program managers to improve each activity. Another key monitoring activity examines six communities to see how various NMEP components work together at the local level. The six case study communities include: Dayton, OH; Sarasota, FL; Tucson, AZ; Eugene, OR; Olympia, WA; and Springfield, MA1. In choosing these sites, HCFA wanted to pick communities based on variations in managed care penetration rates, large employer groups, rural/urban locations, and bilingual populations. HCFA's intention is to continue to study these communities over time, chronicling relevant changes and events within each -- as well as the reactions of beneficiaries and related organizations to the information NMEP provides.

To track the NMEP's overall impact at the national level, a supplement to the winter round of the Medicare Current Beneficiary Survey (MCBS)2 was added in 1999. This was designed to measure the ability of beneficiaries to obtain Medicare information when they need it, and their awareness/understanding of Medicare+Choice messages. The MCBS has included national measures of beneficiary information needs for a number of years, and these will provide data to track changes over time. Additionally, the supplement will be repeated in subsequent years. Since the MCBS only surveys current enrollees, we have developed separate surveys for new managed care members and new enrollees to the Medicare program. The new managed care member survey is collecting information about how beneficiaries made the decision to join the plan and what information they used -- as well as information about their ability to get access to Medicare information when they needed it, their awareness of basic Medicare concepts, and their understanding of the differences among health plans.

The strategy of closely monitoring the effectiveness of different NMEP approaches to providing beneficiary assistance and incorporating lessons learned into future efforts is key to improving efforts to help beneficiaries make more informed health care decisions. Important NMEP activities in the pilot and first year of national implementation are described in the body of this report, accompanied by assessment strategies, findings and improvements made to date.

Print Materials

The Balanced Budget Act of 1997 mandates that general and plan comparison information be mailed to all current beneficiaries by October 15th of each year, beginning in 1999. In early November, 1998, HCFA mailed the first Medicare & You Handbook to 5.1 million Medicare beneficiaries in the five pilot states. A condensed Medicare & You Bulletin was mailed to beneficiaries in the remaining 45 states and territories. HCFA chose a phased-in approach to understand how best to reach beneficiaries about Medicare. That strategy has allowed HCFA to evaluate and test each phase of the ongoing campaign. Changes to Medicare & You 2000 were based on evaluations received from beneficiaries who received the Handbook in 1998. The evaluation of Medicare & You 1999 consisted of four different types of surveys, over 40 focus groups, and expert review (including reviews by low literacy experts). As part of the consumer testing of Medicare & You 2000, approximately 200 cognitive interviews were conducted. This testing showed that most beneficiaries use the Handbook as a reference document; Medicare & You 2000 was revised to reflect this.

Approximately 34 million copies of Medicare & You 2000 were mailed to all Medicare beneficiary households beginning in September 1999. Approximately 200,000 Handbooks are mailed to new Medicare enrollees each month as they become eligible for Medicare. Approximately 1.4 million copies are provided each year to health plans, congressional staff, partners and agents. Through 1-800-MEDICARE, the Handbook is available in English, Spanish, Braille (English only), audio and large print as well as a library edition. There are 26 region/state specific versions of the Handbook with five states requiring more than one version. Select versions of the Handbook also contained a feedback postcard. One Handbook was sent to households with two to four beneficiaries; postcards were sent to beneficiaries in these households giving them information about how to request additional copies. The Handbook includes descriptions of the rights and protections enjoyed by Medicare beneficiaries, new preventive benefits and descriptions of available health plan options including original fee-for-service Medicare and managed care organizations. Changes to Medicare & You 2000 include:

* Information on cover. The monitoring work indicated that many beneficiaries were not aware of what the Handbook was when it came in the mail. Medicare & You 2000 includes information on the front cover describing what is contained in the Handbook and explaining that the document comes from HCFA, the Federal Medicare Agency. * Up-front summary. Rather than reading the Handbook cover-to-cover, many beneficiaries filed it for later reference. Medicare & You 2000 includes three pages summarizing key information for easy reading and to highlight important changes to Medicare. Readers can refer to the Handbook later to obtain more details. * Local plan quality and performance information. The Handbook includes a sample of quality and beneficiary satisfaction information about managed care plans and some quality information about fee-for-service. Additional information is available through 1-800-MEDICARE (1-800-633-4227) and www.medicare.gov. * *Separate booklets.* Specialized material has been moved to separate booklets that can be obtained by those who need detailed information. * Additional feedback. This year HCFA has included a postcard in a sample of Handbooks to gather more feedback for continuous quality improvement.

The percentage of beneficiaries who remember receiving the Handbook has increased from 70 percent (1999 Handbook) to 74 percent (2000 Handbook) according to a survey of beneficiaries in our case study sites. Survey results from February 2000 suggest that most beneficiaries realize that the Handbook is a government publication. Fifty-two percent think that the document is sent by the Medicare program, 10 percent from Social Security Administration, 23 percent from another government agency and 8 percent from an insurance company or a managed care plan. Of those who remember receiving the Handbook, approximately 77 percent had glanced through it, read parts of it, or read it thoroughly. Our focus groups suggest that most beneficiaries skim through the Handbook and then file it away for future reference.

Most beneficiaries find the Handbook "fairly easy" to understand as can be seen in Table 1.

Table 1: "How easy was the Handbook to understand?"

	1999	2000
Very Easy	19%	20%
Fairly Easy	59%	63%
Fairly Difficult	13%	10%
Very Difficult	2%	2%
Refused/Don't Know	7%	5%

Source: NMEP community survey, 1999 and 2000.

The 2000 Handbook is easier for less-educated beneficiaries to read compared to earlier editions. Of those that had obtained at most a high school education, 19 percent found the 1999 Handbook "fairly or very difficult" to read, compared with only 13 percent who found the 2000 Handbook "fairly or very difficult" to read.

The NMEP community survey and the postcard feedback indicate that most beneficiaries are satisfied with the Handbook. The NMEP Community Survey in February 2000 found that 64 percent of beneficiaries are satisfied or very satisfied with the Handbook; 19 percent are neither satisfied/nor dissatisfied, 5 percent are dissatisfied or very dissatisfied and the remaining 13 percent don't know or refused to answer this question. Thus far, we have received approximately 82,000 postcards that were included in a sample of Handbooks. This feedback indicates that 71 percent of beneficiaries think Medicare & You is easy to read, 20 percent neither easy/nor hard to read, and 7 percent think it is hard to read. Approximately, 69 percent say that they could find the information they wanted, 10 percent say they couldn't, and 15 percent say no information was needed. Close to 70 percent of the open-ended postcard comments related to the Handbook were positive and 16 percent were suggestions for revisions to the Handbook. There has also been positive feedback from HCFA partners. Feedback from the National Alliance Network indicates that 78 percent of partners rated the Handbook as very informative; 66 percent rated it as very useful; and 76 percent as easy to read and understandable.

Additional feedback from focus groups on the local information pages in the Medicare & You 2000 suggest that beneficiaries like this section when shown it, but many beneficiaries did not notice it when they received the Handbook last fall. This suggests that the Handbook needs to draw beneficiaries' attention to this section of the Handbook, which we are planning to do for Medicare & You 2001 by using colored tabs designating this section. There was mixed reaction to the CAHPS measure included in the Handbook. For Medicare & You 2000 we had included "How Well Doctors Communicate." We are planning to include a different measure in Medicare & You 2001, which is the "Overall Rating of Health Care." There was some confusion in the presentation of the mammography rate over the term "Original Medicare." Some beneficiaries thought this referred to Medicare in the 1960s. We are trying to clarify this in the quality pages for Medicare & You 2001. Some beneficiaries saw the quality section as work for them since there is a lot of complex information that needs to be absorbed. We are continuing to work towards simplifying this section.

Toll-Free Telephone Services

The Balanced Budget Act of 1997 directs the Secretary to maintain a Medicare Choices Helpline to handle inquiries about Medicare benefits and beneficiary's available options under the Medicare+Choice program.

HCFA phased in the toll-free Medicare+Choice Helpline (1-800-MEDICARE or 1-800-633-4227) between November 1998 and March 1999. The five pilot states received early access to the Helpline. This phased implementation allowed HCFA to obtain feedback from callers to improve operations before national implementation. The toll-free telephone line operates 24 hours a day, seven days a week, and is staffed by customer service representatives between 8 a.m. to 4:30 p.m. local time, Monday through Friday. At other times, the telephone line provides pre-recorded information which can help callers request local Medicare Compare information, copies of the Medicare & You Handbook in English or Spanish, or answers to the most frequently asked questions.

Customer service representatives are available to help answer general Medicare questions and questions related to Medicare health plan choices, process requests for plan comparison information and plan disenrollment forms and make referrals to other information sources where appropriate. The service accommodates both English and Spanish-speaking callers and offers a TTY line (telecommunications device for the deaf and health impaired): 1-877-486-2048.

More than 1.9 million calls have been handled since the November 2, 1998 startup in the five pilot states and the April 1999 nationwide implementation of the Helpline. Currently, approximately 300,000 calls are handled per month. We project that the annual call volume will be 4.6 million calls. The average length of calls is five minutes. Most calls focus on Medicare+Choice options, Medicare benefits, enrollment, replacement cards and coverage issues. The contract requires that 80 percent of all calls be answered within 30 seconds.

Survey data from our case study sites indicate that factors associated with lower Helpline usage among Medicare beneficiaries include: growing older; less education; being in poor health; not having made a change in insurance or not having reviewed coverage during the year; not having noticed publicity about Medicare changes; and having poor knowledge about the Medicare program.

In addition to examining data collected through the calls, including performance on 25 different indicators such as length of call and service level, HCFA has been conducting mystery shopping and a customer satisfaction survey. Through mystery shopping, we are routinely calling the Helpline with specific questions and collecting information on customer service, completeness/accuracy of answers, and referrals offered. In mystery shopping, individuals call the Helpline (posing as either beneficiaries or as friends or family members of a beneficiary) and then ask a question. The caller records customer service characteristics of the call as well as substantive data regarding the information obtained.

Mystery Shopping

Close to 2,000 mystery shopping calls were conducted from the start-up of the pilot through November 1999. The answers for 96 percent of the calls were rated as understandable by the mystery shoppers. During this period, 38 percent of calls made through mystery shopping were put on hold while the customer service representative (CSR) researched an answer and 52 percent received a referral. Eighty-five percent of all callers receiving a referral also received some information from the Helpline. The overall courteousness of the CSRs was rated high with 94 percent of calls opening and closing courteously. Almost all of the answers to calls included correct information. Although over time the completeness of answers to questions has improved, there has been some variation across customer service representatives in terms of how they have answered specific questions. The following is an example of one question that has been asked through mystery shopping with the frequency of different answer components provided by the CSRs.

One question that has been asked 565 times is "My father will be 65 soon and he's been seeing a lot of ads for senior plans and HMOs. What's the difference between these and regular Medicare? Can my father continue to use his current doctors if he enrolls in a Medicare HMO? If he joins one, and doesn't like it, can he switch back to regular Medicare?" Each time the question is asked it is phrased slightly differently. The following are the answer components provided with the frequency that the particular component was mentioned in a call:

Medicare HMOs provide all the benefits of regular Medicare, and often more. (Mentioned in 81 percent of calls.)

HMO enrollees are restricted to using Plan doctors, for Medicare to pay. (Response that restrictions apply in most plans is also correct.) (Mentioned in 80 percent of calls)

HMO enrollees must continue to pay for Part B as well as any premium the HMO charges. (Mentioned in 44 percent of calls.)

Supplemental (Medigap) insurance is not needed with an HMO. (Mentioned in 11 percent of calls.)

You should be certain about the HMO before canceling supplemental insurance policies, because it may be difficult to repurchase that same policy at the same price later, if you decide to leave the HMO. (Mentioned in 3 percent of calls.)

HMO enrollees typically select a primary care physician who coordinates all care; your physician will know if s/he is a member of a Medicare HMO. (Mentioned in 73 percent of calls.)

You can contact the HMOs in your area for a list of the physicians in their plans. (Mentioned in 52 percent of calls.)

You can disenroll from a Medicare HMO at any time, for any reason; you can switch back to regular Medicare or to a different Medicare HMO. (Mentioned in 87 percent of calls.)

To disenroll you should contact the HMO or SSA in writing and obtain the correct forms (CSRs can also offer to send forms); the change you make will become effective the first day of the month after you submit the form/request. (Mentioned in 54 percent of calls.)

Customer Satisfaction Survey

In the customer satisfaction survey Helpline callers are recontacted. This survey provides information about the topic of the call, the satisfaction with the information/service provided, and the demographics of the caller. Close to 3,130 satisfaction surveys have been conducted from start-up through the Fall 1999. In general, callers were satisfied with the service provided by the Medicare representative. Of all callers, 63 percent were very satisfied, 20 percent were satisfied, 4 percent were neither satisfied nor dissatisfied, 4 percent were dissatisfied, 5 percent were very dissatisfied, and the remaining 4 percent refused to answer this question.3 Overall, the majority of callers who spoke to Medicare customer service representatives reported that their calls were handled well. About 35 percent of the callers rated the overall performance as excellent, 41 percent as very good, 17 percent as good, 5 percent as fair, and 2 percent as poor. Regarding specific characteristics, the majority rated all characteristics as either excellent or very good. Callers were the least satisfied with getting the information desired (11 percent rated as fair or poor) and the thoroughness of knowledge of Medicare options (10 percent rated this as fair or poor).

Overall, 56 percent of the callers found the automated system easy to use and 22 percent found it confusing, 3 percent were ambivalent and found it to be neither easy or not easy, and the remaining 20 percent had no comment. The reasons callers gave for confusion with the automated system included: no option matched their concern, they wanted to speak to a live person, there were too many options, the recording went too fast, they did not understand how to use the system or what they were saying, and they did not have touchtone service.

The callers' assessments of how well their questions were answered were, overall, positive: 73 percent of the callers felt that all their questions had been answered, 16 percent felt they had some of their questions answered, and 7 percent felt that none of their questions had been answered. When asked, everything considered including if they were referred to another number, how much trouble did they have to go through to get all the information and answers they wanted, 51 percent said they went through no trouble at all, 21 percent went through a little trouble, 16 percent went through some trouble, and 11 percent went through a great deal of trouble.

Information gathered from these assessment activities is being used to continuously improve the service provided by the Helpline. Based upon feedback received, a number of improvements have been made to the Helpline. These improvements include: streamlining the knowledge base; enhancing training for the customer service representatives; simplifying the automated response unit and including instructions about what buttons need to be pushed in Medicare & You 2000; and increasing the publicity about the Helpline. We are continuing to assess the Helpline to make future improvements in its operations.

Internet

The Balanced Budget Act of 1997 mandated that the Secretary develop an Internet site to provide accurate and reliable general Medicare, plan comparison and quality information. In June, 1998, HCFA launched its beneficiary Internet site, www.medicare.gov. Information on the site currently includes the Medicare & You 2000 Handbook, a new calendar of Medicare & You informational events and activities, lists of resources and phone numbers for beneficiaries and people who work with beneficiaries, general information about Medicare and Medigap Compare. The website also hosts Medicare Compare, which contains detailed comparisons of the benefits and costs and consumer satisfaction surveys and standardized performance measurement systems of available managed care plans across the country. Nursing Home Compare is also located on www.medicare.gov. This section includes detailed information about individual nursing homes around the country. Assessment activities for the Internet site include computer lab sessions followed by focus groups, on-line users "bounceback" surveys4, automated tracking of utilization, expert review of the site, and on-line focus groups.

The medicare.gov site received 3,777,301 page views5 (20,704,348 hits) for the first quarter of fiscal year 2000. As of January 2000 there were 1.5 million page views compared to January 1999 when there were 686,000 page views. The most frequently visited sections of medicare.gov continue to be Medicare Compare and Nursing Home Compare. About 26 percent of the visitors to the site are Medicare beneficiaries. The rest are friends/relative of beneficiaries (26 percent), health professionals (33 percent) and others. The use of www.medicare.gov has increased during the past year among information providers. Beneficiaries are also increasing their use of the Internet. The percentage of beneficiaries with access to the Internet has increased from 6.8 percent in 1997 to 19.5 percent in 1999 (Medicare Current Beneficiary Survey). Internet usage to seek Medicare information is growing among Medicare beneficiaries. According to our NMEP community survey, the percentage of beneficiaries using the Internet to seek Medicare information has increased from 1.7 percent in October 1998 to 3.7 percent in January 2000. Among Medicare beneficiaries, Internet usage to seek Medicare information is negatively associated with growing older, being female, living alone or not being married, having less education, not having made a change in insurance or not having reviewed coverage during the year, and having poor knowledge of the Medicare program.

Most users find www.medicare.gov user-friendly. Approximately 85 percent of users filling out the bounceback form indicated that the site contained useful information, and approximately 92 percent of users indicated that the site was easy to use. Visually impaired focus group participants thought www.medicare.gov was well designed for use with assistive technology.

There are a number of improvements that have been made based on feedback received from users of the site. During computer lab sessions and focus groups, participants often did not notice the search engine; they had trouble finding some of the information available on the site, for example, phone numbers; participants made recommendations about keeping the use of graphics to a minimum for faster loading; and they recommended that the language be simplified and more detail be provided about specific terms such as "Wellness" and "Medicare Compare." Some of the improvements that have been made based on feedback received include: simplifying language; enhancing searching capacity; and making the publication

section more user friendly for novice Internet users. Additionally, recently changes have been made to change the look, navigation and feel of the site to make it more user-friendly (e.g., shrink the image sizes to enable faster response times to pages); and to make it even more user-friendly for the visually impaired.

Since its inception in the spring of 1998, www.medicare.gov has received numerous awards for its outstanding service to the beneficiary community. Examples of the awards the site has received thus far include:

- Gold Award for Best Government Health Site on the Web, November 1999, by EeHealth Care World;
- Silver Award for Best Site for Seniors/Boomers on the Web, November 1999, by eHealthcare World;
- Eye on the Web, August 1998;
- Best Feds on the Web Award, May 1998, by govexec.com;
- Improving Access Award, April 1998, Partnerships '98 Conference; and
- PoliticalSite of the Day, April 1998, by www.penncen.com.

Regional Education About Choices in Health (REACH)

The Balanced Budget Act of 1997 requires that in the month of November each year in conjunction with the annual coordinated election period, the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process. Each of HCFA's 10 regional offices is conducting educational and outreach efforts at the regional, state and local levels. Many of these activities are targeted to meet the needs of specific groups such as African-Americans; American Indians; Latinos; Asian and Pacific Islanders; caregivers; beneficiaries with disabilities who are eligible for both Medicare and Medicaid; and rural beneficiaries. Part of this outreach includes public presentations and exhibits at local health fairs and other health-related events.

The 1998 campaign activities were quite diverse across the regions and the states. As a result in 1999/2000 all regions implemented six core activities through the Regional Education About Choices in Health (REACH) campaign, including media activities, health fairs, educational seminars and public presentations, local district congressional/legislative updates, expanding and enhancing partnerships, and distribution of materials. All regions have used nationally developed materials and the activities have been supported and assessed through single national contractors -- rather than region-specific contractors.

The 1999 REACH campaign that ran from August to December 1999 involved over 3,400 outreach and awareness activities across the country. Table 2 describes the specific activities of the 1999 REACH campaign.

Table 2: Activities for the 1999 REACH

	Number
Presentations	1,549
Health Fairs	366
Public and Partner Meetings	529
Media Activities	384
Training	215
Other	378

A wealth of data has been collected through direct observation of activities, interviews using structured protocols, and interviews with attendees of events, in order to establish a baseline for performance measurement and to analyze activities and best practices.

Enormous differences on the regional, state and local levels (with respect to resources, personnel, and partnerships with others to strategically undertake the challenging schedule in the REACH campaign) impacted the effectiveness and outcomes for the six core activities. Beneficiaries respond very positively to presentations, but relatively few are contacted by this activity. The attendance at health fairs is variable; sometimes the expected attendance is very low. However, over 85 percent of beneficiaries who attended presentations or health fairs were satisfied with the events. The media interventions tend to be more cost effective and reach larger numbers of Medicare beneficiaries.

In the case study sites, 8.3 percent of beneficiaries reported going to some kind of health fair. This varies widely across the sites, with 12 percent attending health fairs in Springfield and 3.6 percent attending in Eugene. More education is strongly associated with health fair attendance. Other factors less strongly associated with health fair attendance include: being in good health; noticing some sort of publicity about changes in Medicare; having greater knowledge about the Medicare program; and going through a change in insurance last year.

Next year we plan to continue to enhance partnerships and increase the use of the social marketing model of information-seeking behavior to better target the REACH activities.

National Alliance Network

To leverage customer service and education efforts and resources, HCFA is building partnerships and alliances with national, state and local organizations. It has created a three-level partnership concept called the NMEP National Alliance Network and has recruited public and private organizations that work on behalf of aged and disabled Americans. The network is structured in three tiers based on level of involvement: (1) Educational Affiliates; (2) Task Force; and (3) Coordinating Committee. The Coordinating Committee is the most active of the three tiers. Currently, there are 43 Educational Affiliates, 16 Task Force member organizations, and 67 Coordinating Committee member organizations. Together with HCFA, these national partners are

reaching out to other organizations at the state and local levels. They, in turn, are working with Medicare beneficiaries and other interested organizations and individuals to help them better understand the changes to the Medicare program.

HCFA is providing information to partners through meetings, conferences, partnership communication kits containing information for dissemination, and a partner's website (www.medicare.gov/nmep). The Coordinating Committee is scheduled to meet four times per year to provide support, guidance and direction to the program. The Task Force is scheduled to meet two times per year to assist in the promotion of the Medicare & You education program. Since May 1998 the Coordinating Committee has met on 12 occasions, and since July 1998 the Task Force has met four times. HCFA has conducted interviews and focus groups to obtain feedback from National Alliance Network partners regarding what has worked well in terms of the partnership and areas in need of improvement. Additionally, feedback is being obtained from a bounceback form that has been placed on the partners? Website to encourage systematic feedback about the site. To date, 92 percent of partners responding to the form have rated the site as mostly or entirely useful, and close to 90 percent feel the site is easy to use.

Both HCFA and its partners reported that the partnering program has been useful. The partners have developed and conducted a number of programs, activities, or events that they attribute to participation in the partnerships. Examples of specific benefits to the partnerships include: using HCFA written materials to distribute to members or clients; using HCFA written materials to design presentations and to develop their own materials; using HCFA information to respond to specific problems, such as HMO plan terminations; and obtaining better information through meetings, calls and the web site.

National Training and Support for Information Givers

More than 700 individuals from HCFA partner organizations across the country have received training about Medicare+Choice and other changes to the Medicare program. The goal is to provide uniform training to the trainers of local front-line beneficiary information/assistance organizations and partners, so that they have the information and tools to teach others in their organizations and communities how to help beneficiaries understand their options. Attendees of these training sessions included HCFA regional offices, Offices on Aging, advocacy groups, carriers, fiscal intermediaries, Peer Review Organizations, the Social Security Administration, SHIPs, and Departments of Insurance. The training sessions were designed to support information intermediaries in their beneficiary education efforts -- primarily by sharing Medicare program updates related to the BBA, using technology to stay current on Medicare information, and using adult learning theory to work effectively with adults and older adults. The curriculum for the training sessions consisted of seven modules: sharing techniques for training adult learners; Medicare resources on the Internet; Medicare & You; Medicare program updates; Medigap and other coverage issues; Medicare: disability and end-stage renal disease; and special topics of interest to beneficiaries.

As a result of feedback from attendees of the training sessions, the training program has been improving over time. For the training sessions conducted for the 1999 campaign, 97.5 percent of all participants felt that the training modules were either

useful or very useful. Ratings of the components of the training averaged 4.28 (on a 5-point Likert scale) or better.

Enhanced Beneficiary Counseling from State Health Insurance Assistance Programs (SHIPs)

The SHIPs are state organizations that receive grant money from HCFA to provide free personal health insurance counseling and assistance to Medicare beneficiaries. Primarily staffed by volunteers, the SHIPs provide local, individual in-person and phone counseling, and group outreach and education about Medicare and other forms of health insurance. Active programs exist in all 50 States plus Washington D.C., Puerto Rico, and the Virgin Islands. Approximately two-thirds of the programs are sponsored through the State Units on Aging and one-third are administered through the State Offices of the Insurance Commissioner. SHIP services are facilitated through about 1,000 local sponsoring organizations, primarily Area Agencies on Aging. The number of volunteers trained to counsel beneficiaries has been increasing. There are over 500 paid full or part time staff at the State and local levels and more than 12,000 highly trained volunteer counselors. All SHIPs have Internet access and 50 SHIPs have toll-free lines.

Assessment activities include interviews with all state SHIP directors, monitoring of changes in volume and content of counseling sessions, and beneficiary survey questions. The monitoring work to date points to the need to develop standard performance measures to assess and evaluate the activities and effectiveness of the SHIPs. Revised performance measures have been identified and pilot tested, and are in the process of being implemented nationwide.

Nearly 2 million beneficiaries are served annually through telephone and face-to-face assistance and outreach activities. The kinds of topics brought to the counselors by beneficiaries have been changing. In past years the traditional Medicare program created confusion around payment, and beneficiaries commonly arrived at SHIP offices with "shoeboxes" full of bills, statements, Explanations of Medicare Benefits, and canceled checks to be sorted out. With improvements in traditional Medicare benefits coordination, fewer beneficiaries need assistance with claims, but counselors' impressions are that more now need help understanding managed care and choosing supplemental plans and HMOs. Findings indicate that approximately 85 percent of those who received counseling (SHIP and other sources of counseling combined) are "very satisfied" or "satisfied" with the service.

SHIP activity levels have increased as a result of the NMEP. SHIP toll-free numbers were published in the Handbook, in NMEP partner materials, and in letters sent to beneficiaries in terminated plans. On average, SHIP client volumes doubled following the November mailing of the Handbook/Bulletin in November 1998. The SHIPs received many client inquiries related to this mailing, primarily about the premium assistance information on the back page of the Bulletin. However, the increase in client volumes could not be attributed solely to the NMEP. During the fall 1998, there was an increase in the number of Medicare HMOs announcing decisions to withdraw from certain markets as of January 1, 1999. These withdrawals affected over 400,000 beneficiaries in 27 states (one percent of all beneficiaries nationwide), and up to ten percent of beneficiaries in some states. Some SHIPs reported receiving a large increase in calls due to inquiries from affected beneficiaries. Preliminary

information for most states indicates that the spike in client volumes during Fall 1999 will not be as high as it was during Fall 1998. However, some states report that managed care marketplace changes (primarily plan withdrawals) have resulted in client volume increases that are as large or larger than last year.

In addition to the services provided to beneficiaries directly, monitoring activities in the pilot state communities confirm another important impact of the SHIP programs. Interviews with many local organizations, state partners, and HCFA/regional officials indicate that the SHIP organizations have consistently made important contributions to the NMEP organizational and implementation efforts at state and local levels. Their experience and awareness of beneficiary needs, as well as their willingness to assume important state and local roles in NMEP activities, have had a notable impact upon the success of the HCFA partnership strategy.

Targeted and Comprehensive Assessment of Education Efforts

A key monitoring activity examines six communities6 to see how various NMEP components work together at the local level. Community case studies include interviews and focus groups with key information providers, as well as surveys and focus groups with beneficiaries living in these communities.

In the six case study sites, there were substantial managed care market changes from 1998 to 2000. These changes included fewer available Medicare managed care plans over this period, reductions in benefits, increased premiums, and disruptions in provider networks. Table 3 contains information about Medicare enrollment, managed care penetration, and the number of managed care plans available over this period.

Table 3: Medicare Population, Medicare Managed Care Enrollment and Number of Plans by Study Site - 1998 and 2000

	1998 Medicare Enrollment	2000 Medicare Enrollment	1998 Managed Care Penetration	2000 Managed Care Penetration	1998 Medicare Plans in Study Site	2000 Medicare Plans in Study Site
Sarasota, FL	94,422	95,881	12.1%	11.3%	4	2
Dayton, OH	144,988	142,873	16.8%	16.5%	4	3
Tucson, AZ	119,234	121,754	48.8%	49.1%	7	4
Springfield, MA	74,487	73,381	21.3%	21.6%	5	3
Eugene, OR	47,068	47,130	45.9%	45.0%	4	3
Olympia,	25,202	25,846	37.2%	41.4%	4	4

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About 11 percent of beneficiaries changed between Original Medicare and managed care or among managed care plans. Managed care penetration was essentially flat in 5 of the 6 case study sites. Most changes were among managed care enrollees switching plans due to plan terminations and major benefit reductions. The choice behavior of beneficiaries who were in terminating plans varied across the markets. In some sites, where remaining plans are still aggressive marketers, virtually all beneficiaries in terminating plans switched to another managed care plan. In other sites, beneficiaries were observed to more frequently return to Original Medicare. About 17 percent of beneficiaries sought managed care information, primarily from managed care plans. The SHIP program was the second most frequent source for managed care information.

There is evidence from the surveys in the case study sites in Fall 1998, Winter 1999 and Winter 2000 that many beneficiaries lack a basic understanding of the Medicare program. In 1999 and 2000, we found that 18 percent and 17 percent of beneficiaries surveyed, respectively, were not familiar with the terms managed care plan, HMO, or health maintenance organization although managed care does exist in all of these communities. The percentage of beneficiaries knowing that Medicare does not cover all health care costs has increased from 85 percent in October 1998 to 89 percent in February 2000. Nearly half of the case study beneficiaries (46 percent) know that if you join an HMO, you do not have to leave the Medicare program. Approximately a third (36 percent) of beneficiaries know that HMOs can raise their fees or change their benefits every year.

From our focus groups with beneficiaries, as well as our interviews with counselors and organizations helping beneficiaries, we have found that there was not a significant demand for general Medicare information from beneficiaries. It appears that most beneficiaries seek information about Medicare on an "as needed" basis. That is, when an event in their life triggers a need for information -- such as initial Medicare eligibility, a change in existing coverage, the onset of a serious medical condition, termination of a health plan, or death of a spouse -- a beneficiary is motivated to seek information about Medicare. In the case study sites, we saw an increase in beneficiaries seeking information as a result of : the pullout of Humana in Sarasota; Anthem announcing it was withdrawing from the Medicare program and then increasing its premiums and reducing benefits instead in Dayton; and HMOs imposing a cap on drug benefits where there had previously been unlimited coverage in Springfield.

The frequency of seeking Medicare information in the case study sites is positively related to being married, having more than a high school education, having reviewed or planning to review insurance coverage, and having a change in their insurance in the past year. Overall, and for almost every specific type of information channel, there is a very strong pattern showing that persons more knowledgeable about Medicare (based on a set of knowledge questions asked on the survey) are the highest users of information. More knowledgeable persons may choose to obtain more information, or persons accessing more information may become more knowledgeable. Beneficiaries who experienced an HMO withdrawal, a physician withdrawal from a network, or an employer changing retiree benefits sought information more frequently and from more information sources than unaffected beneficiaries. Twenty-three percent of surveyed beneficiaries experienced one of these changes. Use of formal and informal sources of information differ by

subgroups. For example, beneficiaries living alone are, not surprisingly, more likely to use providers as a source and less likely to use family and friends or plan representatives as a source. Non-white beneficiaries are more likely to use family and friends than whites, and far less likely to use plan representatives.

In the case study sites, there were generally a large number of organizations providing Medicare-related information to beneficiaries. For example, across the sites there were from 4 to 11 organizations providing face-to-face counseling, 4 to 10 hotlines to obtain Medicare information, and 1 to 5 newsletters going out to the Medicare population. How well the organizations providing information coordinated their activities with the other community organizations varied widely across the sites. For example, Dayton, OH has a group called the Ohio Medicare Partners, which collaborates on activities related to providing information to Medicare beneficiaries; thus, there is a more formal, coordinated effort in Dayton. The information supplied was clearly dominated by plans and insurers, and organizations with related business interests.

To date, most NMEP planning efforts have taken place at the state, rather than the local level. State partners in several sites have developed a coordinated approach to Medicare outreach and event planning. However, there is less evidence of an overall NMEP strategy at the local level. While some effort locally has been devoted to distribution of newsletters and articles, much of the effort of the NMEP at the local level has been devoted to face-to-face communication.

To monitor the overall education effort, the MCBS includes a number of questions to track (over time) the ability of beneficiaries to get Medicare information when needed, awareness of basic Medicare messages, and perceived level of knowledge. Data collected from the Winter 1999 MCBS supplement suggest that 67 percent of beneficiaries had their Medicare questions answered by the information that they received through Medicare information sources7. As part of the 1999 supplement, Medicare beneficiaries were read the statement, "Most people covered by Medicare can select among different kinds of health plan choices within Medicare." Forty-seven percent of MCBS respondents said this statement was true, 10.5 percent said it was false, and 42.4 percent were not sure. When read the statement "Medicare without a supplemental insurance policy does pay for all of your health care expenses," 6.9 percent said this was true, 75.3 percent said it was false, and 17.7 percent were not sure. When asked in the Spring 1999 "How much do you feel you know about the availability and benefits of Medicare managed care plans," 25 percent said I know everything or most of what I need to know; 16 percent said some of what I need to know; and 58 percent said little or almost none of what I need to know. In contrast, when asked "How much do you feel you know about what medical services Medicare covers or does not cover," 41 percent said everything or most of what I need to know; 28 percent some of what I need to know; and 30 percent little or almost none of what I need to know. These and other measures will be tracked over time to measure improvements in the ability of beneficiaries to access information and in their awareness and knowledge about basic features of the Medicare program, including the Medicare+Choice options.

The intensive monitoring of the NMEP pilot and the first year of national implementation has found that beneficiaries primarily seek information when needed, and are often not responsive to information supplied at other times. Medicare information needs to be targeted to specific populations, or to populations coping

with specific situations such as newly enrolling in Medicare, termination of a health plan, loss of a spouse, or an important health event. HCFA is in the process of determining how best to address this important issue more effectively. As part of the Regional Education About Choices in Health (REACH), regional NMEP officials are continuing to develop programs to target specific demographic/ethnic groups. The monitoring also found that beneficiaries lack basic information about the Medicare program. Thus, HCFA is continuing to try to convey this basic information to Medicare beneficiaries through the NMEP.

Future Plans for the Assessment of the NMEP

In the period since the kick-off of the five-state pilot in November 1998 (with the Helpline launch and the Handbook mailing), usage and indicators of effectiveness of all NMEP activities have been aggressively monitored through mystery shopping, nearly a dozen different surveys, special research projects, dozens of focus groups, and interviews with more than two hundred local officials and experts in pilot states and other communities. These monitoring activities continue to provide evidence of where communication activities and products are working as intended and where further improvements need to be made. As expected, HCFA is learning important lessons from monitoring activities, but much remains to be done. HCFA plans to continue the monitoring and assessment efforts to promote ongoing improvement in NMEP activities.

Appendix A

Health Care Financing Administration

National Medicare Education Program Budget

Fiscal Years (FY) 1998 and 1999

UF-denotes Medicare+Choice user fees
PM-denotes HCFA program management funding
PRO-denotes peer review program apportionment

Budget Line Items	FY 1998 Obligations		FY 1999 Obligations	
	Obligations	Major Activities	Obligations	Major Activities
Beneficiary Materials	$22.4M ($18.2M-UF) ($4.2M-PM)	Based on handbook mailing to 5 pilot states; bulletin to all others	$48.1M ($33.9M-UF) ($14.2M-PM)	National handbook mailing and a variety of brochures and pamphlets about M+C and Medicare

1-800-MEDICARE (toll free line)	$28.7M ($27.3M-UF) ($1.4M-PM)	5 state pilot and phase-in approach October 1998; national implementation; March 1999	$23.5M ($23.5M-UF)	Full year national operation
Internet	$1.5M ($1.5M-UF)	To support design, development and testing of Medicare Compare interactive database	$2.2M ($1.5M-UF) ($600K-PM) ($100K-PRO)	Design, development & testing of new web sites and enhancements to existing web sites
Community-Based Outreach	$24.8M ($14.8M-UF) ($10M-PM)	Primarily to support SHIPS and execution of the education campaign at the local level	$36M ($14M-UF) ($22M-PM)	Transition of SHIP grants to 18 month cycle and increased support at local level; new access initiatives (Horizons)
Program Support Services	$17.6M ($12.1M-UF) ($4.5M-PRO) ($1M-PM)	Primarily to support CAHPS, assessment, social marketing and training	$27.5M ($17.7M-UF) ($7.6M-PRO) ($2.2M-PM)	Increase in CAHPS support, promotion & publicity, social marketing, training
TOTALS	$95M ($73.9M-UF) ($16.6M-PM) ($4.5M-PRO)		$137.3M ($90.6M-UF) ($39M-PM) ($7.7M-PRO)	

References

Health Care Financing Administration (HCFA). Medicare Current Beneficiary Survey, 1999. Kirsch I, Jungebult A, Jenkins L, Kolstad A., Adult Literacy in America: A First Look at the Findings of the National Adult Literacy Survey. Washington, DC: National Center for Education Statistics, US Department of Education; 1993.

1. Five of these communities were in the five pilot states in 1998.

2. The MCBS is a longitudinal panel survey, sponsored by HCFA, of a representative sample of Medicare beneficiaries, including the aged and disabled.
3. To provide some comparison in terms of the satisfaction levels, we looked at two questions on the Medicare managed care Consumer Assessment of Health Plans (CAHPS) Survey. On the CAHPS survey there is a question about whether the beneficiary called the health plan's 1-800 number and whether there was a problem getting help. Close to 31 percent of the respondents called their plan's 800 number and 66 percent of those using the number said that it was not a problem to get help.
4. A bounceback form for the Medicare & You Handbook was initiated in October 1998. The purpose of the bounceback form was to elicit systematic response from Internet users who have "visited" the online version of the handbook and to collect a demographic profile of the users. From October 26, 1998 through May 25, 1999, 14,624 responses were received to the Medicare & You bounceback form. For the overall web site, an additional bounceback form was initiated in April 1998. To date, we have received 7,359 responses to the overall web site bounceback form.
5. A page view counts a page as a whole regardless of the number of images or other files that page contains.
6. Five of the communities were in the pilot states and one community was in a non-pilot state.
7. This includes beneficiaries who went to the following sources to get answers to their Medicare questions: the insurance company that processes Medicare claims; the Medicare office (including the telephone hotline); the Medicare counseling program; and Medicare publications.